DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. BUILDING _____ B. WING _____	03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PLACE AT MARYVILLE	2648 SEVIERVILLE RD MARYVILLE, TN 37804

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F 000	INITIAL COMMENTS An Recertification and complaint survey, #32654, #32643, and #33126, were completed on March 20, 2014. No deficiencies were cited in relation to complaints #32654 and #32643. A deficiency was cited in relation to complaint #33126 under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000	F 225 – The abuse allegation for Resident #4 was summarized in the UIRS report #201412015227, but a separate UIRS report was not submitted. All future abuse allegations will be reviewed by the newly formed Compliance Review Team (Administrator, Assistant Administrator, DON and HR Director) prior to UIRS submission to ensure complete investigation and documentation of the allegation. The Administrator has re-educated the management team (Administrator, Assistant Administrator, DON, Social Services Director, Dining Director, Chaplain, Marketing Director, Activities Director, Executive Assistant, Assisted Living Manager, Facilities Director, Housekeeping Manager, IT Director, Rehab Director) on the new process for reviewing and reporting abuse allegations through the UIRS system.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225		4/6/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tessa L. Brewer	Administrator Resubmitted	6/11/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to report an allegation of possible abuse to the proper authorities for one resident (#4), of three residents reviewed for abuse or neglect. The findings included: Resident #4 was admitted to the facility March 15, 2013, with diagnoses including Dementia with Depression and Chronic Pain of the Right Lower Extremity related to Disability of the right knee joint due to a history of Osteomyelitis. Medical record review of the annual assessment from the Minimum Data Set (MDS) dated February 19, 2014, revealed the resident was born March 28, 1922, had a Brief Interview of Mental Status (BIMS) score of 6 out of a possible 15, (which indicated severe cognitive impairment) "usually understood" and "usually understands" staff, and required extensive assistance to transfer to the wheelchair for locomotion. Review of the facility's investigation file of an	F 225	All abuse allegation investigations will be audited to determine proper review and reporting for the next 3 months by the Compliance Review Team (Administrator, Assistant Administrator, DON and HR Director). The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

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F 225	Continued From page 2 allegation of abuse from January 2014, revealed a written statement, dated January 14, 2014, was included. Review of the written statement revealed the allegation of abuse included two residents being abused. Review of the information included in the report sent to the State's incident reporting system (IRS) revealed only one of the two residents had their medical record number and complete information submitted in the report. Review of the facility's Abuse Policy, last revised July of 2010, revealed, "Alleged violations...reported...to other officials in accordance with State law..." Interview with the facility Administrator on March 18, 2014, at 1:20 p.m., in the conference room, revealed the Administrator was the facility's Abuse Officer. Further interview confirmed the allegation of possible abuse of resident #4 had not been reported to the appropriate State Agency. Complaint #33126	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 – Medication times for Resident #116 have been reviewed for appropriate times and resident preference by the DON, resident and family representative. The DON and Staff Development Coordinator conducted in-services for all nursing staff on the Medication Administration policy. In-Services were completed by 4/11/14. New nursing employees will receive education on the Medication Administration Policy during new employee orientation.	4/11/14

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F 281	Continued From page 3 Based on medical record review, facility policy review, and interview, one of three nurses failed to follow the facility's policy and provide services that met professional standards. The findings included: Review of the March 2014, Medication Administration Record for Resident #116, with Registered Nurse (RN) #1, on March 18, 2014, at 7:45 a.m., at the 2 South Nurse's station, revealed RN #1 had initialed the following medications as administered on March 18, 2014 at 9:00 a.m.: 1. Pot Chloride (potassium chloride - mineral) Liq (liquid) 10% scheduled for administration at 9:00 a.m. 2. Acetylcyst Sol (solution) (reduces mucous secretions) scheduled for administration at 9:00 a.m. and 9:00 p.m. 3. Famotidine Tab (tablet) (inhibits gastric acid) 20 mg (milligram) scheduled for administration at 9:00 a.m. and 9:00 p.m. 4. Fluoxetine Cap (capsule) 40 mg (antidepressant) scheduled for administration at 9:00 a.m. 5. Furosemide Tab 20 mg (diuretic) scheduled for administration at 9:00 a.m. 6. Ipratropin/ Sol Albuter (aerosol treatment to aid with breathing) scheduled for administration at 9:00 a.m. and 9:00 p.m. Review of the facility policy Medication Administration revealed "...medications shall be administered as prescribed...in accordance with Professional Standards of Care...7. Medications may not be set up in advance and must be administered within one (1) hour before or after	F 281	The DON and RN Supervisors will conduct random audits on 10 residents per week for 4 weeks, then 10 residents per month for 3 months to check for proper administration of medications according to the Medication Administration Policy. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

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F 281	Continued From page 4 their prescribed time..." Interview with RN #1 on March 18, 2014, at 7:45 a.m., at the 2 South Nurse's station revealed the medications had been administered more than one hour before the administration time and the facility policy had not been followed.	F 281		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 – The unknown, unlabeled medication inside the 2 North Nurse's Medication Cart was discarded per protocol. All remaining medication carts were checked for any unlabeled or open medications. No unlabeled or open medications were found. The DON and Staff Development Coordinator conducted in-services for all nursing staff on the Medication Administration policy. In-Services were completed by 4/11/14. The DON and RN Supervisors will conduct random audits on 10 residents per week for 4 weeks, then 10 residents per month for 3 months to check for proper administration of medications according to the Medication Administration Policy.	4/11/14

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F 431	Continued From page 5 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly label and store medications in one medication cart of three medication carts observed of the eight medication carts in the facility. The findings included: Observation on March 20, 2014, at 1:20 p.m., at the 2 North Nurse's Medication Cart, with the Director of Nursing, revealed an open clear plastic medication cup in the drawer of the medication cart with four unknown, unlabeled medications inside. Interview with the Director of Nursing, at the time of the observation, confirmed the medication had not been labeled or stored correctly.	F 431	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F 441 – (1) LPN #1 and LPN#2 were re-educated by the Staff Development Coordinator on proper protocol for glucometer cleaning on 3/20/14.	4/11/14

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F 441	Continued From page 6 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Infection Control Line Listings, facility policy and inservice review, observation, and interview, the facility failed to: 1) maintain aseptic technique when disinfecting blood glucose meters; 2) maintain a functioning	F 441	The DON or Staff Development Coordinator will in-service all nursing staff on proper protocol for glucometer cleaning. In-services were completed by 4/11/14. New nursing employees will receive education on the proper protocol for glucometer cleaning during new employee orientation. The DON and RN Supervisors will conduct random audits on 10 glucometer checks per week for 4 weeks, then 10 glucometer checks per month for 3 months to check for proper protocol used for cleaning the glucometers. (2) The DON has been named the Infection Control Coordinator. (3) The Infection Control Line Listing for the facility has been reviewed and revised to include a listing of the organisms identified.	

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F 441	Continued From page 7	F 441	The DON and Staff Development Coordinator conducted in-services for all nursing staff on the proper protocol for filling out the Infection Control Line Listing document. The DON will conduct an audit of the Infection Control Line Listing monthly for the next 3 months to ensure that the organisms identified have been included in each infection on the log. (4) The quarantine policy and procedure was reviewed and revised. Revisions include a check list to be followed for any quarantine – which specifies notification of the local health officer. The Administrator, DON and Staff Development Coordinator will re-educate all management and nursing staff on the new quarantine policy and procedure.	

Infection Control Coordinator; 3) maintain an accurate record of identified infective organisms; and 4) failed to follow the facility's policy for reporting to local or county health officers.

The findings included:

1) Review of the March 2014 Inservice states, "...Glucometer...Clean the glucometer between residents:
Apply gloves
Wipe glucometer then place the saniwipe around the glucometer, leaving the glucometer wet for 2 minutes.
Set timer
Remove saniwipe
Remove gloves..."

Interview with Licensed Practical Nurse (LPN) #1 on March 20, 2014, at 1:20 p.m., at the 2 North Nurse's Station, with the Director of Nursing present, revealed the glucometer on the medication cart was cleaned with a Sani-cloth and allowed to set for thirty seconds then it was ready to be used.

Interview with LPN #2 on March 20, 2014, at 1:30 p.m., at a medication cart on 1 South, with the Director of Nursing present, revealed the glucometer on the cart was cleaned with an alcohol wipe and then was ready for use for the next resident.

Interview with the Interim Director of Nursing at the time of the interviews with LPN #1 & LPN #2 confirmed neither one of the cleaning routines described by LPN #1 & #2 followed the criteria of the inservice and neither cleaning routine would disinfect the glucometers appropriately.

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F 441	Continued From page 8	F 441	Any further quarantines over the next 6 months will be audited by the Administrator for proper implementation of the policy and procedure, to include notification of the local health officer. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

Review of the facility's policy Infection Control-Identification of Infection revealed, "...2. c. To identify and treat epidemiologically important organisms...4. The Infection Control Coordinator will report surveillance information to the Infection Control Committee performing infection control oversight functions..."

Review of the facility's policy Infection Control-Reportable Diseases revealed, "...4. The occurrence of outbreaks or clusters of any illness which may be of public concern whether or it is known to be communicable in nature, shall be reported to the local health officer of the county in which it occurs."

2) Interview with the facility Administrator on March 19, 2014, at 9:10 a.m., in the conference room, revealed the Administrator named Licensed Practical Nurse (LPN) #3 as the Infection Control Nurse for the facility.

Interview with LPN #3 at 9:30 a.m., on March 19, 2014, in the conference room, revealed LPN #3 denied functioning as an Infection Control Nurse and stated, "I am only responsible for data entry."

Interview with the Interim Director of Nurses (DON) at 9:50 a.m., on March 19, 2014, in the conference room, revealed the previous DON had been the Infection Control Coordinator, the Interim DON had not been assigned to the position, and the facility presently did not have a functioning Infection Control Coordinator.

3) Interview with the Interim DON at 3:00 p.m., on March 19, 2014, in the conference room, revealed the Infection Control Line Listing for the

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F 441	Continued From page 9	F 441		

facility from October 2013, through to the present time did not consistently list "Organisms Identified (If known)" in the required column of the month to month line log. Interview continued and confirmed the staff routinely, and incorrectly, entered the disease in the column provided for the infective organisms if known. Further interview confirmed the facility presently had three residents on one nursing unit identified with pneumonia, there were no infecting organisms identified, there was no indication of whether the pneumonia was viral or bacterial, but all three residents were being treated with antibiotics.

4) Interview with the facility administrator on March 19, 2014, at 9:10 a.m., in the conference room, confirmed the facility had an outbreak of communicable diseases as follows: the Lakeview Terrace unit from October 9, 2013, through October 28, 2013, of nausea/vomiting and/or diarrhea; the Village unit from October 10, 2013, through October 24, 2013, of a respiratory illness; and the Smokey's View unit from October 21, 2013, to November 1, 2013, of both a diarrhea and respiratory illness. Further interview revealed the public was not allowed on these units during these intervals. Continued interview revealed the facility had not followed their policy and notified the local health officer.